RECOMMENDATIONS
OF
THE ADVISORY PANEL ON
AMBULATORY PAYMENT CLASSIFICATION GROUPS
August 22, 2003

BLOOD AND BLOOD PRODUCTS

1. The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the Panel) recommends that the Centers for Medicare & Medicaid Services (CMS) freeze payment rates for blood and blood products (including, at minimum, whole blood, red blood cells, platelets, albumin, and factors 8 and 9—specifically excluding recombinants) at 2003 levels.

2. The Panel further recommends that the suggested payment freeze in Recommendation #1 above apply for 2004 and 2005.

3. The Panel recommends that the American Association of Blood Banks (AABB) and the American Red Cross (ARC) educate hospitals regarding coding and billing for blood and blood products with the implicit, clearly identifiable endorsement of CMS to validate AABB's and ARC's educational initiatives.

4. The Panel recommends that APCs for blood and blood products be on the agenda for the January 2004 meeting in time for consideration of the 2005 payment rates.

NUCLEAR MEDICINE, BRACHYTHERAPY, AND RADIOSURGERY SERVICES

1. The Panel recommends that CMS should change the HCPCS code descriptors for radiopharmaceutcals to be on a 'per-dose' basis—not on a 'per-unit' basis.

2. The Panel recommends that APCs for radiopharmaceuticals be on the agenda for the January 2004 meeting.

3. The Panel recommends that CMS move forward with the categorization system in the proposed Outpatient Prospective Payment System (OPPS) 2004 rule absent strong, reasoned opposition from provider groups. If strong opposition is revealed, the Panel recommends that CMS maintain the current system that is in place for 2003.

4. The Panel recommends that CMS staff analyze the claims for the nuclear medicine APCs and do the following: itemize the costs, determine what proportion of the median cost can be attributed to radiopharmaceuticals, and present the data at the Panel's January 2004 meeting.

5. When itemized cost data for nuclear medicine APCs are available, the Panel should reconsider whether the dollar threshold for radiopharmaceutical packaging (currently $150) should be revised. Using these data, the Panel will also consider whether CMS inaccurately pays for claims when the packaging of radiopharmaceuticals at the current thresholds is in place.

6. The Panel recommends that CMS review whether the codes for needles and catheters were included in the payment rate proposed for APC 313.

7. The Panel recommends that CMS consider outside data presented by commenters in establishing payment rates for APCs 312 and 651 to arrive at an appropriate payment rate.

8. The Panel recommends that CMS discontinue use of G codes and use appropriate Current Procedural Terminology (CPT) codes paid in clinical APCs when making payment for these services.

9. The Panel recommends that CMS review issues concerning whether the use of x-ray guidance (as opposed to CT or U/S guidance) for radiation therapy delivery is being properly reported and/or included in the payment rates for radiation treatment delivery.

10. The Panel supports the proposed payment rate for APC 412 absent compelling evidence showing claims data are wrong.

11. The Panel supports the proposed payment rates for G0251 and G0173 until more data are available. The Panel will review the issue further at its January 2004 meeting.

12. Regarding changes proposed by commenters to G0242 and G0243, the Panel will review these in January 2004 at which time it requests that professional societies representing neurosurgeons, radiation oncologists, and others considering these changes deliver comments.

PAYMENT AND CODING FOR DRUG ADMINISTRATION

1. The Panel recommends that CMS continue to use Q codes (and not institute new G codes) in revising the drug payment system and that the Agency uses codes Q0081, 0083, and 0084. The Panel members also recommend that CMS allow billing Q0081 on a per-visit basis, and they recommend deleting Q0085. The Panel further recommends that CMS consider Option 4 over Options 2 and 3 of the drug administration proposals.

2. The Panel recommends that CMS clarify that hospitals can report Q0081 more than once on a claim if the patient has more than one visit in a day for fluid administration and/or non-cancer drug therapy.

3. Due to the wide variation in costs associated with drug preparation, the Panel recommends that CMS look into pharmacies' costs for preparing drugs, and this issue should be more closely examined at the Panel's January meeting.

4. The Panel is seriously concerned about the dollar threshold for the packaging of drugs and about the adequacy of payment for separately paid drugs. However, the Panel is uncomfortable recommending anything without an alternative approach in place. Therefore, the Panel requests that CMS staff present at the January meeting alternative options, such as an APC structure for drugs and radiopharmaceuticals, both packaged and separately paid.

5. The Panel recommends that CMS delete C9010.

DEVICES

1. The Panel recommends that CMS use any publicly available, credible data for setting the payment rate for APC 107. It also recommends that CMS consider both the cost of the device and the cost of the procedure when setting a payment rate for this procedure.

2. The Panel recommends that CMS change the status indicator (SI) for CPT code 61885 to S (in APC 222).

3. The Panel recommends that CMS assign all new CPTs for central venous access devices into appropriate APCs (either clinical APCs or new technology APCs). Where appropriate, the Panel recommends that CMS use external data in making assignments. The Panel would like to review the assignments at its next meeting in January 2004.

4. At the January 2004 meeting, the Panel recommends that CMS present all APCs (in spreadsheet format sorted by change in median cost and having a threshold for the Panel's consideration). After reviewing this information, the Panel will give CMS its views.
5. The Panel recommends that CMS use any publicly available, credible data for setting the payment rate for APC 386.

6. The Panel recommends that CMS staff review adjustments to APC 46 and make recommendations to the Panel in January concerning any changes.

7. Since the catheter to perform this particular procedure costs $600 and is now buried in the cardiac catheter payment, the Panel recommends that CMS staff change CPTs 93571 and 93572 from the current SI "N" to an appropriate SI that allows payment under the APC system.